Author’s response to reviews

Title: How do community-based eye care practitioners approach depression in patients with low vision? A mixed methods study

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Author’s response to reviews:

We have addressed the editor's and reviewer's comments in detail, for ease of reading, please refer to the two attached Word documents:

1) Editor's comments (Cover letter to editor)
2) Reviewer's comments (Response to reviewer's comments)

Response to reviewer's comments also duplicated here for completeness:

Nollett et al: Response to reviewer’s comments

Please note that all page and line numbers given refer to the tracked changes version of the revised manuscript.

1. This paper explores an important area and has the potential to make a valuable contribution. However, there are a number of revisions required prior to being ready for publication.

Response: We thank you for your acknowledgement of the importance of this work and have made substantial revisions based on your comments, which we believe have improved the quality of the paper.

2. The introduction focuses a little too narrowly on the clinic at hand and would benefit from greater engagement and location of the problem in the broader literature. For example, the introduction should expand slightly on depression in low vision and vision loss, especially to outline risk of depression onset and/or prevalence of comorbid depression. The depression in VI literature is not engaged with in enough depth.
Response: We have expanded the information on depression in low vision and put it in context by adding a paragraph to the introduction (Pg3 lines 13-24):

“There is a well-established link between low vision and depression: people with low vision are 2-5 times more likely to experience depression or significant depressive symptoms [9-11]. For example, a large population based study of older adults in the UK found that the prevalence of significant depressive symptoms in those with low vision was 13.5% (compared to 4.6% in those with good vision) [9]. In those attending low vision rehabilitation clinics, 37-43% were found to have significant depressive symptoms [12, 13], and the prevalence of Major Depressive Disorder was 5.4% (compared to 1.2% in people with normal sight) [10]. One explanation for the increased risk in this group is the Activity Restriction Model of Depressed Affect [14], which posits that depression results from having to relinquish valued activities. Vision loss is known to lead to high levels of functional impairment, impacting on activities of daily living [11] and engagement in hobbies and social activities [15, 16]. This impairment is likely compounded by co-morbidity with other chronic conditions such as diabetes and stroke, both of which are more prevalent in people with low vision [6].”

We have further removed the focus on the LVSW clinic by significantly reducing the text referring to it and placing the reduced text later on in the introduction (Pg 5, lines 6-8), only after we have located the problem in the wider literature. Also, some of the text removed has been placed in the Methods section (Pg 6 lines 22-23).

3. Likewise, reasons for low detection and treatment of depression in this population in practice should be explored more, especially given the low detection of depression in older adults generally.

Response: We have added a paragraph (Pg 4 lines 1-13) drawing on the broader literature to explore why depression is often under-recognised in older people and those with chronic conditions, which make up the large majority of people with low vision:

“The presence of depression in people with chronic conditions can lead to poorer treatment adherence [17] and engagement in rehabilitation, resulting in poorer overall outcomes [18, 19] and increased functional disability and health resource utilisation [2]. It is important depression is diagnosed and treated, however, depression often goes undetected by clinicians [20]. Some people with depression, particularly older adults, fail to present with low mood and instead report non-specific or somatic symptoms such as change in appetite, sleep problems of low energy [21]. In elderly patients or those with chronic conditions, it is easy for clinicians to mistakenly attribute these symptoms to the physical illness or ‘old age’, thereby missing depression [18, 22]. These views are often held by elderly patients themselves [23]. In addition, they have difficulties expressing their moods [24] and beliefs around stigma which may prevent them from seeking help [25], compounding the chances of under-recognition by primary care clinicians who may not possess the skills or confidence to detect depression [23]. Finally, older adults with poor vision are among those least likely to be recognised as having depression in primary care [26].”

4. Locating routine depression screening including benefits and costs within the broader chronic health literature on depression screening in practice is also needed.

Response: We have added a paragraph (Pg 4 lines 15-26, Pg 5 lines 1-5) highlighting some of the guidelines which recommend depression screening in chronic health, discussed some of the pros and cons of routine depression screening and the complications with implementing screening:
“To address under-detection of depression, several U.S. and Canadian national guidelines recommend routine screening for depression in people with chronic illness [27-29]. The UK’s National Institute of Health and Care Excellence (NICE) advises practitioners working in primary care and in general hospital settings to be aware that patients with a chronic physical health problem are a high risk group, particularly where there is functional impairment, and that they should be alert to possible depression. They suggest practitioners consider asking patients two screening questions (known as the ‘Whooley questions’) [30], with referral for assessment if the result is positive. There is much debate about the pros and cons of routine screening for depression. Evidence suggests it can lead to diagnosis of new cases and early intervention [31], however this will only occur when provided alongside effective management strategies [32]. Potential harms include identifying false positives, possibly leading to unnecessary distress and wasted resources [33], and an increase in consultation time [33]. Moreover, whilst screening using a short validated tool appears to be a simple procedure, it is in fact a more complex intervention when screening for depression [34, 35]. Alderson et al [34] identified five barriers to screening for depression in chronic health settings presented by staff, patients and systems, and recommend that all those involved need to be prepared in advance of the introduction of screening into a service. With regard to professionals, they suggest examining their attitudes towards and skills in detecting depression prior to implementation.”

5. The rationale for the paper will be strengthened once the study is better located within the extant literature. It will also better suit the wide readership of the journal.

Response: As per the responses to 2-4 above, we have added considerably to the introduction to locate the study within the depression/low vision literature and, more broadly, the literature on depression in chronic illness and the elderly. We feel this will make it applicable to a wider readership.

6. The research questions need to be reworked with some rationale provided around use of mixed methods, and how these questions sit within current knowledge gaps.

Response: We have simplified and condensed the research questions (Pg 6 lines 4-6):

“1) What is community low vision practitioners’ current practice around identifying and responding to depression in patients with low vision?
2) What characteristics and beliefs are linked to their current practice?”

In the introduction, we have highlighted the current knowledge gaps to explain why these questions need to be addressed (Pg 5 lines 16-25, Pg 6 lines 1-3):

“ A qualitative study conducted in a tertiary eye care hospital in Melbourne reported on eye care practitioners’ beliefs, practice and perceived barriers to working with depression [37] and a further series of quantitative studies with eye health professionals in hospitals and private practice in Australia [38-40] concluded that interventions, including training programs, are required to improve depression management within eye care services. Aside from these studies, there is a paucity of evidence in this area, particularly in regard to community and UK based low vision practitioners.

Therefore, there is a need to understand: if/how community low vision practitioners currently identify and manage depression and the characteristics, beliefs and barriers linked to their practice, prior to the introduction of routine screening in low vision services. In addressing these knowledge gaps, the results will help to inform the development of a training programme to support low vision practitioners in Wales, and internationally, to screen and manage people with low vision and depression.”
We have also clarified the use of both quantitative and qualitative methods and how they address questions from different angles, in both the Introduction (Pg 6 lines 7-12):

“The study used quantitative and qualitative methods in a mixed methods design to answer the two questions. Questionnaire measures, routine data and individual interviews were used all to address Question 1. The questionnaires were also used to investigate the characteristics linked to current practice (Q2), whilst the interviews examined practitioners’ beliefs related to their practice (Q2). The findings were integrated in a mixed methods analysis, providing a more complete understanding than would be provided by either method alone [41].”

and Methods sections (Pg 7 lines 4-14):

“This study employed a cross-sectional design using baseline data from an ongoing study. Given the paucity of previous relevant literature, we used a convergent mixed methods design [41] to obtain both a quantitative and qualitative understanding of current practice (see Figure 1.). The quantitative aspect included both a questionnaire [38] and routinely collected data, to allow an investigation of general trends in clinical practice (behaviour) around addressing depression, whilst the individual interviews were used to explore in-depth personal perspectives on the subject. The questionnaire was also used to examine associations between practitioner characteristics and practice, whilst the interviews sought to understand practitioner beliefs which influenced their practice. The results from the two datasets were compared in a mixed methods analysis, thus providing a more comprehensive understanding than either method alone could give [41, 44].”

7. Method needs to explicitly state what training/background is of practitioners.

Response: We have added a few sentences to the Participants section of the Methods to clarify this (Pg 6 lines 22-24, Pg 7 1-2):

“The service is provided by low vision practitioners who are eye care professionals (optometrists, dispensing opticians and an ophthalmic practitioner). In addition to the core training required for registration with their respective professional bodies, all practitioners are required to complete the College of Optometrists Certificate in Low Vision (course details [43]) and undertake a process of re-accreditation on a 3 yearly basis”.

8. Given that the questionnaire did not use previously validated measures, more details including on development should be provided.

Response: The questionnaire scales were validated previously in one study using Rasch analysis and we have added text to clarify this point (Pg 7, lines 24-25):

“We utilised four sections of a questionnaire developed for use with eye care practitioners and employed and validated in previous research [39] (See Additional file 1 – Study Questionnaire).”

We have also added further detail on the original development of the questionnaire and the reference to refer to for full details of the development and validation (Pg 8 lines 1-3):

“The scales used in the questionnaire were developed from scales used with professionals working with the elderly. They were refined through focus groups with eye health professionals and validated using
Rasch analysis (for a full description of original questionnaire development, refer to Rees et al [39]).

9. The testing and refining process also needs to be expanded upon. There is reference to psychometric assessment of the questionnaire but the psychometrics including validity and reliability are not reported.

Response: The psychometric assessment results were reported in Additional File 2 – Rasch Methodology. However, we note this was not clear and have re-named the file to Additional File 2 – Rasch Methodology & Results.

We have also added some text to the main results section to confirm the psychometric properties, before pointing the reader to the additional file for full details (Pg 13 lines 14-17). We have avoided using the words reliability and validity as these refer more to Classical Test Theory, and instead reported psychometric properties relevant to Rasch analysis:

“The three questionnaire scales were Rasch analysed and, after iteratively removing misfitting items and those displaying DIF, they displayed adequate psychometric properties, with ordered response thresholds, no misfitting items or item bias, and minimal evidence of multidimensionality (See Additional File 2 – Rasch Analysis Methodology & Results).”

Due to the length of the paper, we considered the Rasch methodology and results best placed as an additional file, however, we will accept an editorial decision as to whether either should be moved to the main paper.

10. The measures and procedures are quite interwoven - the methods would be clearer if these sections were more clearly delineated.

Response: We have separated the information on the measures and procedures and reported them in two distinct sections (Pg 7 and Pg 9).

11. It is unclear in the statistical analysis section how the audit data will be used. How risk of depression is determined needs to be made more explicit.

Response: In the Measures section, we have added detail to explain how the risk of depression might be determined, as there is currently no standard procedure for doing so in the LVSW (Pg 8 lines 16-22). We hope it is now clearer that there is variability in how this might be assessed. Prior to this study, there was no information on exactly how practitioners identify depression and chose to tick this box on the record card:

“Completion of a low vision record card by the LVSW practitioner is a requirement for every patient assessment conducted. It consists of clinical details of the patient and check boxes to indicate specific risks faced by the patient, including depression. There is currently no formal requirement for practitioners to screen for risk of depression. Hence, any instances of risk of depression being recorded are based on the practitioner’s own assessment: this may have occurred through use of a standardised screening tool if they are familiar with one, or it may be a more informal judgement.”

In the Procedures section we have added a statement to explain that using the record card data provides a somewhat more objective indication of how many practitioners are currently considering and recording depression in their current practice over self-report on the questionnaires/interviews alone.
Data from all record cards completed by all practitioners (other than those excluded from the study) during the 6-month period from 1st July to 31st December 2017 were collated to determine the number of practitioners who identified a risk of depression in any instance. This would give a somewhat more objective indication of how many practitioners are currently considering and recording depression in their current practice over self-report on the questionnaires/interviews alone.

Finally, in the analysis section we have clarified that we used descriptive statistics to report the number and percentage of practitioners recording instance of risk of depression for at least one patient:

“With regards to the record card data, descriptive statistics were used to describe the number and percentage of practitioners who had recorded at least one instance of a patient being at risk of depression to determine how many practitioners identify and record depression as part of their current practice.”

12. For the qualitative section - again please separate information regarding the interview and the procedure. An overall procedure section would make the methods clearer.

Response: Accordingly, we have separated the information about the interview and the procedures, using one overall procedures section, rather than separate sections for the quantitative and qualitative sections, which we feel makes the methods clearer.

13. The term measures can be replaced when overviewing the interviews.

Response: Accordingly, we have replaced the word ‘Measures’ with the term ‘Qualitative Interviews’.

14. This section needs more information regarding the focus of the interviews, what sorts of questions were asked, how they were developed and what information was aiming to be gained.

Response: We have revised the Qualitative Interview paragraph to clarify the focus/aim of the interview, the number and content of questions asked and how the topic guide was developed:

“In-depth semi-structured interviews were conducted with individual participants using a topic guide developed by the research team. The guide was designed to elicit information to answer the two research questions and to allow comparison with the data gained from the questionnaires. Four open-ended questions were based around the three questionnaire scales and asked about participants’ current practice around identifying and responding to depression in people with low vision, their confidence in working with people with depression and their perceived barriers. Four further questions examined their understanding and personal experience of depression, perceptions of their role and training needs. The guide was reviewed by the Qualitative Research Group (Centre for Trials Research, Cardiff University) and piloted with an optometrist not taking part in the study. As a result of both, some questions were re-worded to elicit specific examples and prompts were added to the main questions to encourage more detailed information in the instance the respondent was not forthcoming.”

15. Given the purposive sampling for the interviews, more details are needed regarding how/why
this sample was selected and a stronger rationale for this is needed.

Response: We have added a paragraph to the Procedures section to explain the rationale for the sampling strategy (Pg 9 lines 12-23). We have removed the reference to purposive sampling and instead focused on explaining our rationale for using maximum variation sampling (a sub-type of purposive sampling), giving more detail on how and why the sample was selected:

“The aim of the qualitative interviews was to identify common patterns of beliefs and practice across LVSW practitioners. Given the variety in their demographic and professional characteristics, and that these characteristics may well influence their beliefs and practice, we selected potential interview participants using maximum variation sampling. This is a sampling strategy which aims to identify shared patterns across variations in participants [46] and involves selecting participants across a spectrum [47], in this case, of demographic and professional characteristics. The LVSW Clinical Lead reviewed the list of practitioners and selected a potential sample of participants based on a mix of demographic (eg. age, gender, location) and work-related (eg. length of service, job role) characteristics. Practitioners were emailed an invitation and Participant Information Sheet (PIS). To minimise the pressure to consent, interested practitioners were asked to contact an independent researcher (CN) and consenting participants remained anonymous to the Clinical Lead and other study team members.”

16. Who was the interviewer and was there any relationship with the practitioners?

Response: The interviewer and her background are specified on Page 10 Line 1-3. However, we have clarified “she has a background in mental health research and practice” and “and was unknown to the practitioners” (Pg 10 lines 2-3):

“All of the interviews were conducted by one author (CN), an experienced researcher who has a background in mental health research and practice, is independent from the LVSW and was unknown to the practitioners.”

17. Ethical issues around clinical lead recruitment clinicians need to be better addressed. Notably, there is no mention of ethics in the paper.

Response: Ethical approval and participant consent are mentioned in the dedicated section at the end of the paper, as per the journal format (Pg 34 lines 9-12).

However, we have also now added this to the methods section and noted that the study was undertaken in line with the Declaration of Helsinki (Pg 6 lines 15-18):

“The study was granted ethical approval from the School Research Ethics Audit Committee at the School of Optometry & Vision Sciences, Cardiff University: ref 1472 . All participants were given information sheets about the study prior to providing consent and all practices followed the guidelines of the Declaration of Helsinki [42].”

We have also addressed the potential issue of the clinical lead recruiting clinicians. We clarified that, although the Clinical Lead (being the only person with access to the practitioner details) sent out the invitation to take part in the questionnaire, the online responses were anonymous so she could not determine who hadn’t responded, therefore minimising pressure to take part (Pg 10 lines 15-17):
“From an ethical point of view, and because of the sensitive nature of the topic, their responses were anonymous so the Clinical Lead could not trace who had consented, thus minimising the pressure to agree to the research aspect.”

In terms of the interview recruitment, we clarified that whilst the Clinical Lead sent the original invite, practitioners were asked to contact an independent researcher if they were interested. Hence, the Clinical Lead would not know if someone did or did not agree to take part (Pg 9 lines 20-23):

“To minimise the pressure to consent, interested practitioners were asked to contact an independent researcher (CN) and consenting participants remained anonymous to the Clinical Lead and other study team members.”

We also acknowledged this as a limitation in the discussion (Pg 32 line 25):

“In addition, it would have been preferable for a researcher independent of the LVSW to have invited practitioners to take part, however, it was only logistically possible for the Clinical Lead to do so in this study.”

18. More details of the exact type of thematic analysis undertaken are needed (eg Epistemological position? Etc).

Response: The type of thematic analysis undertaken was Braun and Clarke’s approach, as stated in the Qualitative Analysis section on Page 12 line 3. We have added more details to this section to clarify our epistemological position was a realist one and codes were developed at a semantic level (Pg 12 line 7-9):

“The analysis was approached from a realist perspective (reporting an assumed reality present in the data [50]) and codes were developed at a semantic level, by examining the surface meeting of the data.”

We have added more regarding our inductive approach (Pg 12 lines 3-6):

“The data were analysed in a primarily inductive way, in which the codes were driven by the content of the data, rather than applying a coding framework based on prior theories or ideas. However, codes were then organised into themes with the two research questions in mind, rather than a purely inductive way.”

19. The qualitative analysis section needs more depth and clarity. How was NVivo incorporated and at what stage, how were higher order themes determined, how was this integrated with reflective journals and field notes?

Response: We have added more detail to this section and made the steps undertaken more explicit. We have made it clear how NVivo was used, how the higher order themes were generated and how the journal and field notes were used in the analysis (Pg 12 lines 11-20):

“The first step was familiarisation with the data through listening to the interviews whilst reading the transcripts, noting any initial reflections in the journal. This was followed by inductive coding of the data, giving equal attention to each interview. Coding was initially carried out on each transcript before
being transferred to copies of the transcripts stored in Nvivo (v11). The latter was then used to organise (rename, combine, and divide) the codes. The final codes were printed and grouped together on paper under initial potential themes. The themes were checked against the interview transcripts, reflexive journal and field notes and discussed with two independent qualitative researchers to refine them and ensure they remained close to the original data. They were then discussed with the research team who defined and named the final themes. The themes were then incorporated into a written narrative evidenced with data extracts.”

20. The presentation of the results section could be clearer - consider revising the subheadings to be more concise and focused.

Response: We have revised the sub-headings in line with the new research questions, which are themselves more focused. We then condensed the research question further to provide concise subheadings for the results section (Pg 15 line 1 “Research Q1: Current practice around identifying and responding to depression” and 11 “Research Q2: Characteristics linked to current practice”).

21. Provide specific results regarding Q2 - it is stated that practitioners had low confidence, but not actual numbers or findings are reported. At least some basic results need to be reported in text or the main paper in a table and not only as supplementary material. The same applies to the barriers information.

Response: As per comment 24 below, we have condensed the quantitative result section. This was achieved through removing text which did not directly address either research question, including the information cited above. As a consequence, we have not added any further results in support of the redundant text.

22. The mixture of assessment types is introduced for the first time in the results and needs to be covered in the method.

Response: We have added information on the professional/work characteristics collected, including mixture of assessment types under the Quantitative Measures Section of the Methods (Pg 8 lines 4-8):

“Part A of the questionnaire consisted of questions to record demographic information (age and gender) and professional/work-related characteristics. The latter included information on job role, place of work, length of registration/service, number of patient seen per month, time spent with patient and type of assessment (that is, do they provide practice based or domiciliary assessments, or a mixture of both).”

23. Also report the model statistics for the regression models, and report adjusted r squares for regressions.

Response: We have added the model statistics and adjusted/pseudo adjusted r squared for the regression analyses in an additional row in Tables 2. (Pg 15) and 3. (Pg 16) respectively.

24. The thematic analysis would benefit from more engagement with the questions asked and how these shape responses. Some of the sections were a little brief and as such the claims do not appear fully supported. Outlining subthemes, especially in theme three might be useful.
Response to Comments 24 and 26: We thank you for your helpful suggestions on refining the presentation of the thematic analysis. We have re-structured these findings, leading to a clearer, more focused analysis which is also closer to a true inductive analysis.

Firstly, we combined the data from the Part b in the original manuscript (how practitioner perceptions influence practice) into the three main themes (Please see comments on pgs 17-25). This leads to a better flow of how practitioner perceptions influence their practice. It also results in fewer, more in-depth sections, overcoming the issue of some sections being too brief.

Secondly, we have removed the research question sub-heading. We have added sub-themes where appropriate and re-organised the data under these sub-themes. Again this has improved the structure and focus of each theme (Please see comments on pgs 17-25).

Finally, we have reviewed the quotes and added a few stronger quotes to strengthen our claims (Please see comments on pgs 17-25).

25. The quantitative results section could probably be more condensed and presented with more tables, leaving more space for the qualitative analysis.

Response: We have considerably condensed the results section, removing findings which did not directly address either research question (as stated in Comment 20). This has made for a shorter, more focused quantitative results section (Pgs 13-16).

26. It is odd to intersperse the thematic analysis with research question sub headings - this does not fully fit with the presentation of an inductive analysis and the presentation of this section should be reworked and better integrated into the themes presented.

Response: Please refer to response to comment 24 – the research subheading has been removed and the data originally under that sub heading has been integrated into the three main themes, more in line with an inductive analysis (Please see comments on pgs 17-25).

27. The training needs do not flow well and would be better placed in the discussion.

Response: We have moved these and summarized them in the discussion section (Pg 31 lines 15-26, pg 32 lines 1-3):

“Before implementing routine screening for depression into this or any chronic illness service, practitioners need to be fully prepared [56] and practitioners themselves expressed a need for training. Firstly, they require the knowledge to confidently identify possible cases of depression, including information on key signs and symptoms. Use of a simple validated screening tool such as the two Whooley questions [30] may improve rates of case finding and practitioners’ confidence in a ‘correct’ assessment, over relying solely on intuition. However, this would entail addressing depression directly, which is something practitioners currently avoid. Therefore, a key element of a training program would also need to cover communication skills including how to initiate and contain a conversation about depression and how to respond to emotion. Screening by itself does not improve patient outcomes [32]. Hence, any service needs to establish a clear referral pathway. For the LVSW, it has been established that referral to the GP is part of the service protocol. To feel confident with this recommendation, practitioners would also need advice on negotiating patient consent and writing the referral letter.
Trainners would also need to challenge practitioners’ beliefs that depression is inevitable and patients will not benefit from treatment, for referrals to occur.”

28. Likewise impressions on reasons for confidence etc are better placed in the discussion not the results section as these are speculative interpretations rather than findings.

Response: We have removed these speculative interpretations entirely.

29. The mixed methods results are not introduced or discussed and only presented in a table - some in text outlining would be beneficial.

Response: We have added text to introduce Table 4. (Pg 26 lines 3-6):

“The quantitative and qualitative findings were merged and compared for confirmation, complementarity, expansion and discordance. Three key findings around the use of screening tools and influences on current practice resulted in expansion, with the interviews expanding and explaining the results shown in the survey data. There was one instance of discordance between the two datasets, around the percentage of practitioners aiming to identify depression. Reasons for this are considered in the discussion. None of the results from the two datasets were considered to result in confirmation or complementarity.”

In response to the general comments about clarity, we have also re-worked the text in the table, adding subheadings and removing unnecessary text, to improve clarity, brevity and focus. (Pg 26 & 27).

In the discussion we have added comment on the mixed methods results (Pg 29 lines 14-22):

“The mixed methods analysis revealed that the qualitative dataset largely overlapped with and expanded the data collected in the questionnaires, providing insights into the questionnaire responses. There was one instance of discordance: the majority of practitioners interviewed reported trying to identify depression, compared to only a third on the questionnaire. This discrepancy may be for a number of reasons. Firstly, it could be due to social desirability. The interviewees may have told the interviewer what they thought was the ‘correct’ answer ie. they do try to identify depression. Alternatively, it may have been influenced by the time available to interview participants to reflect on and discuss their practice with the interviewer. For example, two practitioners initially said they did not try to identify it, before changing their mind and realising they did so on an informal basis.”

30. The discussion needs to be notably reworked. The first paragraph of the discussion should highlight key findings and provide a stronger summary.

Response: We have reworked most of the discussion, including an initial paragraph summarizing the key findings (Please see Pgs 28 & 29 lines 1-12 for summary of key findings).

Please see responses to comments 31-34 for further reworking of the discussion.

31. The discussion focuses too much on differences between survey and interview and is very speculative and appears to introduce new information. Focus more on interpreting the results and locating them within the broader literature.
Response: We have removed the focus on discussing differences between the survey and interviews and added several paragraphs locating the results within the broader chronic health and older adult literature (Please see pg 30 lines 8-26 & pg 31 lines 1-11).

32. There are very few references in the discussion and much literature that is not engaged with.

Response: See response to Comment 31., we have added several paragraphs locating our findings in the broader literature, adding multiple references to previous work in low vision (Please see pg 29 lines 24-26 & pg 30 lines 1-6) and chronic health and the elderly (pgs 30 & 31).

33. This paper has scope to really provide clear implications for practice and but currently does not do this enough. Broader use of routine depression screening in other health care contexts should also be engaged with when making recommendations.

Response: We have added a sub heading ‘Implications for Practice’ and provided recommendations based on our findings and those from literature on chronic illness/elderly (pg 31 lines 13-26 & pg 32 lines 1-5):

“The majority of practitioners in the LVSW do not yet routinely assess low vision patients for depression and feel they lack the knowledge and skills to do so effectively. Before implementing routine screening for depression into this or any chronic illness service, practitioners need to be fully prepared [56] and practitioners themselves expressed a need for training. Firstly, they require the knowledge to confidently identify possible cases of depression, including information on key signs and symptoms. Use of a simple validated screening tool such as the two Whooley questions [30] may improve rates of case finding and practitioners’ confidence in a ‘correct’ assessment, over relying solely on intuition. However, this would entail addressing depression directly, which is something practitioners currently avoid. Therefore, a key element of a training program would also need to cover communication skills including how to initiate and contain a conversation about depression and how to respond to emotion. Screening by itself does not improve patient outcomes [32]. Hence, any service needs to establish a clear referral pathway. For the LVSW, it has been established that referral to the GP is part of the service protocol. To feel confident with this recommendation, practitioners would also need advice on negotiating patient consent and writing the referral letter. Trainers would also need to challenge practitioners’ beliefs that depression is inevitable and patients will not benefit from treatment, for referrals to occur. Similarly, the concerns about patient reluctance to acknowledge their depression would need to be addressed. Perhaps presenting screening as a normal and routine part of care may help reduce feelings of shame and give patients ‘permission’ to discuss depression [56].”

34. Also consider that some ORs were very close to 1 and some CIs very wide and this needs to be noted in the discussion of those results.

Response: We have added a note of caution about the wide CIs when discussing this finding (Pg 28 lines 16-18):

“ We note that the confidence intervals for the logistic regression finding regarding dispensing opticians were wide, possibly due to the small number of this profession in the study (and the service). Therefore this finding should be interpreted with caution.”
Our statistician (author TP) supports the interpretations with respect to the ORs.